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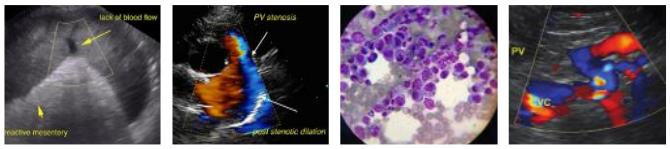


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Tuesday Phillips

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

3yr

WEIGHT

8.0lb

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Dr. Rivera

HOSPITAL NAME

DPC Veterinary Hospital

REFERRING VET

Dr. Ward

INVOICE

13407ag

DATE

04/05/2023

PRESENTING CLINICAL SIGNS

Reason for Visit: Weight loss and goopy discharge from mouth History: 3 y/o s,f dsh presents for rapid weight loss that has been going on for a couple of months, more noticable now. Appetite has increased the last 2 months but is still losing weight. Since last visit O says that P has lost a lot of her bottom teeth. P has been drooling more and O has noticed that a thick, sticky, goopy discharge coming out of the mouth as well which started today. P has also been throwing up at least a couple of times a month for the last 2 months. C/S/V/D: no c/s/d, V+ E/D/U/D: increased appetite, d/u/d Diet: Purina (dry) and sheba (wet) FAS Score: 0-1, very sweet but a little nervous Current Medications (dose and frequency): Lysine powder supplement (SID) Heartworm Prevention / Flea Prevention: none Known Allergies and Medical Conditions: Leukemia + (confirmed 10/26/2019) Microchip ID: / No microchip Vital Signs Weight: 8lbs Temp:100.1 HR: 140 RR: 40 MM/CRT: pale pink, moist/<2s

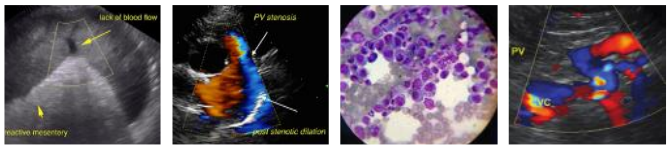
Abnormal PE/Chem/CBC/UA Results: Morning Physical Exam S. QAR. Weight unchnaged from yesterday=8.0lb. Owner gave pred and gabapentin at 8:30am. O. Hydration: Estimate 5-7% dehydration Mentation: QAR EENT: OU clear. Moderate brown debris AU. No cough on tracheal palpation. Oral cavity: Stomatitis/gingivitis--subjectively improved slightly since yesterday; dental calculus, pale mucus membranes Lymph Nodes: Submandibular, prescapular and popliteal lymph nodes normal size, shape and consistency Skin: Healthy hair coat. No ectoparasites seen, skin clean dry and intact. CV/Respiratory: Tachycardia, grade 3/6 systolic murmur rule-out viscosity murmur less likely myocardial disease; pulses fair and synchronous, normal bronchovesicular sounds. Abd/GI: Uncomfortable on mid-abdominal palpation. Large fluctuant urinary bladder. Uro/Perineum: No lesions or abnormalities. Musculoskeletal: BCS = 4/9. Ambulatory x 4, normal gait, normal palpation all 4 limbs. good muscle condition Neurological: Alert and appropriate. No deficits noted. A. Non-regnerative anemia; FeLV positive; gingivitis/stomatitis rule-out uremia vs. primary immune-mediated, low liver enzymes, albumin slightly low P. Cystocentesis for in-house UA Abdominal ultrasound with STAT consult Admitted to hospital--IVC placed. LRS 30ml/hour over the first hour, then re-assess Doctor: Ward for Cepero Testing Performed: Healthchek Plus Results: CBC: ANEMIA Hct=18%, non-regenerative, no blood parasites detected Chem: Severe azotemia, low albumin, low liver enzymes SDMA=28 (0-14) Crea=5.9, suspect falsely decreased due to decreased body condition per notes BUN=113 (15-37) Phos=15.5 (2.9-6.3) TCO2=11 (12-22) Albumin-2.5 (2.6-3.9) rule-out renal loss vs. negative acute phase protein vs. decreased hepatic production Low ALT=12 (27-158), low AST=12 (16-67), low ALP=6 (12-590) TT4 WNL Recommendations: UA, hospitalization/IVF, anti-emetics, abdominal ultrasound, mycoplasma PCR vs. trial of Veraflox Retesting Needed? see above Prescriptions to Dispense: Spoke to Owner/LMOM? LMOM for owner to call back ASAP due to concerning changes on bloodwork. Allison Ward, DVM Owner called back immediately. Discussed concerns with bloodwork and need for IV diuresis and further diagnostics--owner will bring patient in right now for admittance to hospital. Discussed ideally 24-hour hospitalization for diuresis, but cost may be prohibitive. Owner elects to start here. Allison Ward, DVM

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Normal size and margination were present in the kidneys. Mild uniform cortical hypertrophy with mild increased cortex echogenicity was present. Adequate medullary volume with mild bilateral pyelectasia was present. No evidence of retroperitoneal inflammatory criteria. The left kidney measured 3.6 cm in length. The right kidney measured 3.9 cm in length.



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The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left and right adrenal glands were not definitively visualized. No obvious pathology was present in the area of the bilateral adrenal glands.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 0.71 cm in width at the level of the hilus.

Liver/Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate ingesta exhibiting mild progressive distal acoustic shadowing with no signs of ileus, obstruction or foreign material. The ventral gastric body wall measured 0.23 cm in width.

The visualized segments of small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine contained segmental to generalized ingesta and luminal gas with no signs of ileus, obstruction or foreign material. The small intestine wall measured 0.18 cm in width.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Non-specific nephropathy.
- Overtly normal liver/gallbladder.
- Overtly normal GI tract with gastric and segmental to generalized intestinal ingesta/gas.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sonographically the bilateral kidneys did not appear to be end stage which may indicate the possibility of acute on chronic nephropathy. Given the patient's anemia which may be secondary to chronic renal disease or FeLV, chronic nephropathy to chronic renal failure may be more probable. Assessment for possible renal toxic insult may be considered if clinically indicated. UA, C/S and baseline UPC is suggested. Assessment/monitoring of systemic BP is recommended. A GI panel to include

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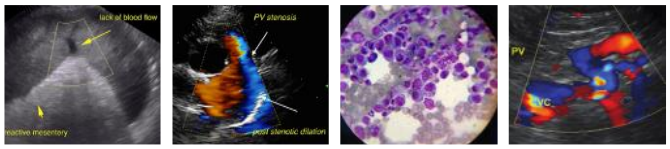

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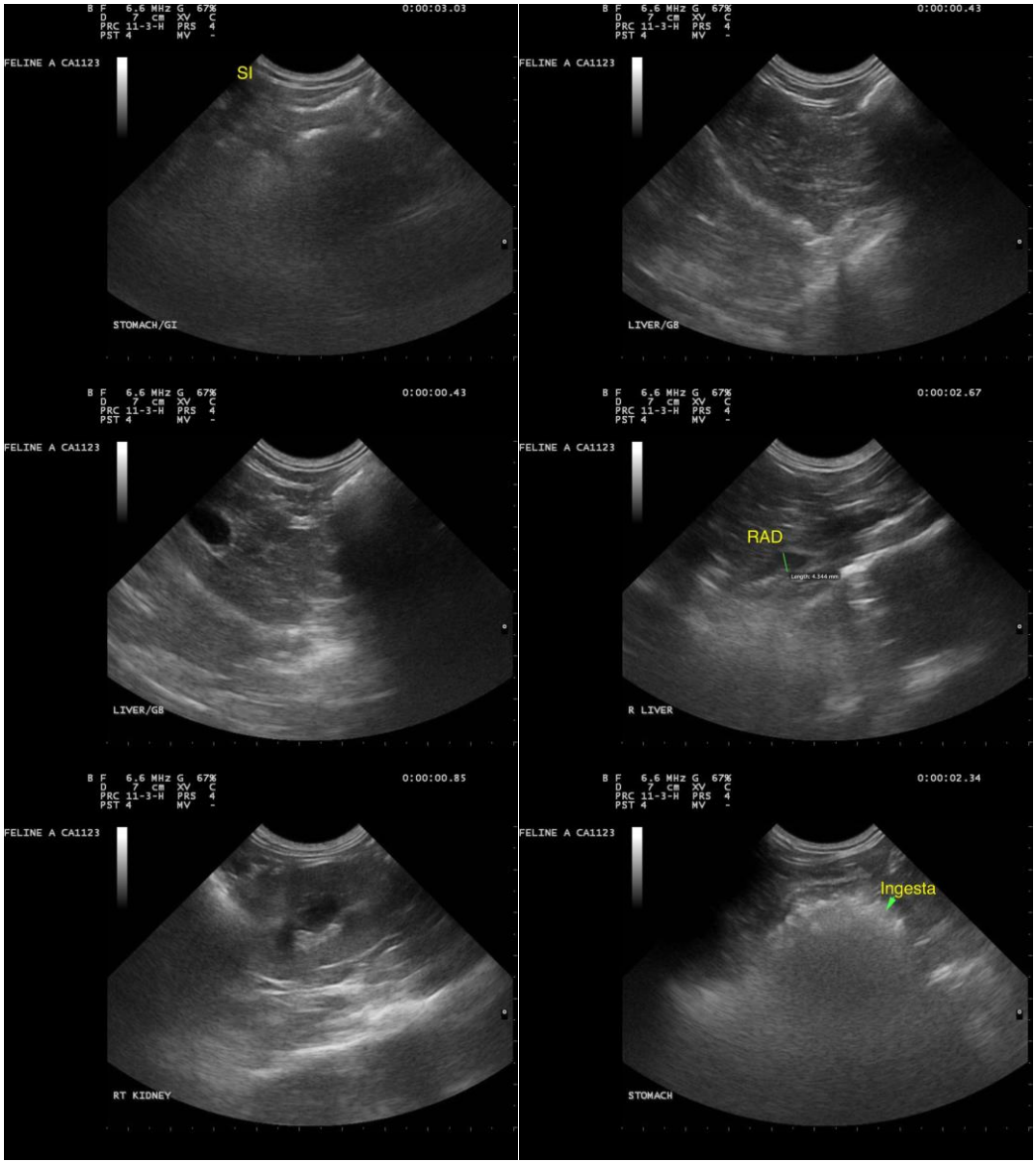
PLI/TLI/Cobalamin/Folate may be considered to assess for occult intestinal or pancreatic disease as a contributing factor to the patient's weight loss. No obvious evidence of intra-abdominal neoplastic criteria. Pre and post prandial bile acids may be indicated if persistent decreased hepatic enzyme levels or clinical concern for hepatic dysfunction. Given the degree of azotemia and pending additional diagnostics, prognosis is likely dependent on renal response to diuresis and a guarded prognosis is indicated.



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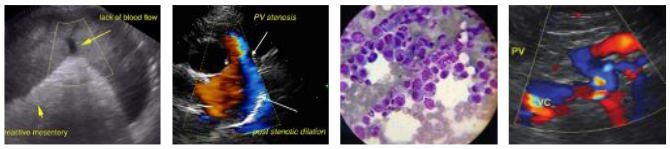

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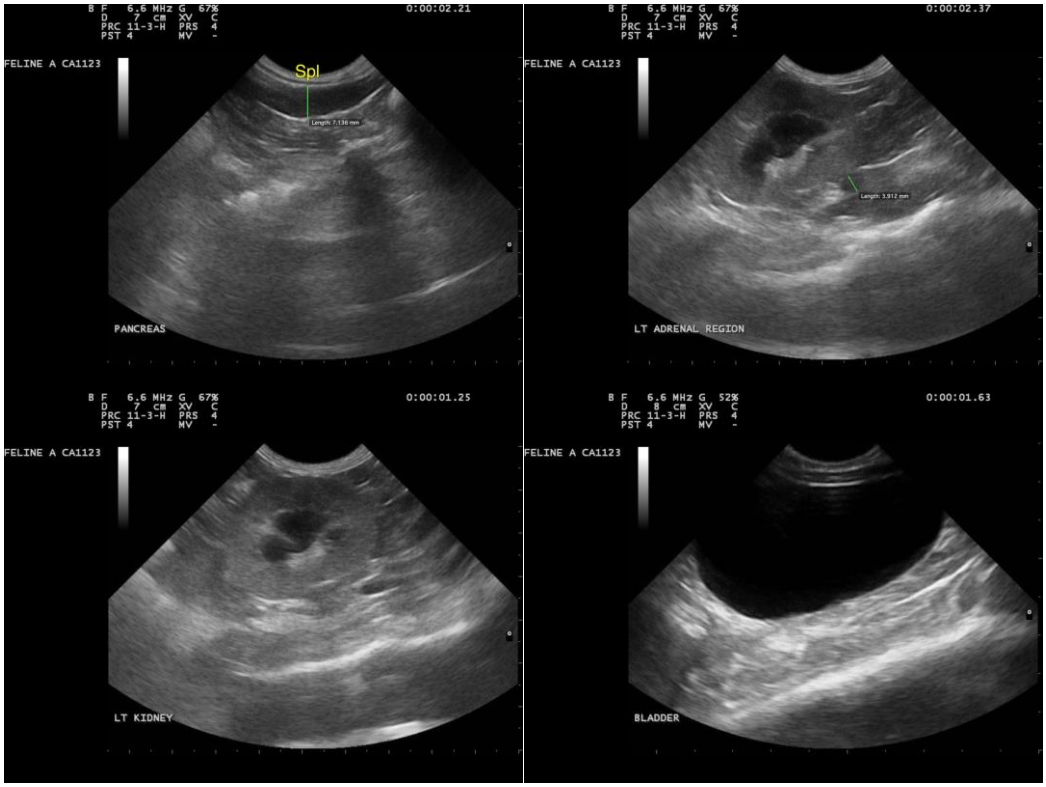

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
mac.daniel@sonopath.com